This Pathway & Protocol is intended to guide Admission to and Discharge from the Unit. The Aim of the Stroke Unit is to provide early and continuous multi-disciplinary assessment, intervention and rehabilitation. It will also facilitate discharge and joint working across care settings.

Admission to Raigmore
- Refer to Protocol “Where should a patient with suspected stroke or TIA be treated”
- Patients with a TIA do not need to be routinely admitted

Acute Medical Admission/Medical Specialist Care Unit (Ward 6A)
- Criteria for Admission to Stroke Unit [Box 2]
- Appropriate patients should be transferred within 24 hours of admission to the hospital

Stroke Unit (2nd Floor, 23 beds) (Acute Care & Rehabilitation)
- Transfer within Raigmore [Box 3]
- Discharge Planning will be begin on Admission to the Unit

Care in Other Wards
- Transfer to Stroke Unit [Box 3]

Transfer of Care from Raigmore Hospital [Box 4]
- Whenever possible, and as clinically appropriate, patients should be transferred as close to home as soon as possible
- Appropriate Referrals should be made to Hospital or Community based Services (including Social Services, Community Rehabilitation Team, Community AHPs, CHSS Stroke Nurse, Day Hospital, Voluntary services)
- Discharge Planning & Criteria [Box 4]

Follow Up Support and Assessment [Box 5]
- Patients should be reviewed by the specialist/stroke service within 3 months of discharge.
- All patients post discharge from the unit will be followed up by the CHSS Stroke Nurse 2 weeks post discharge
- Patients requiring ongoing support will be followed up by their relevant GP and primary care team
**Box 1: Assessment & Referral**
- A Member of Stroke Unit Team will visit/liaise with 6A on a daily basis (including week-ends)
- All individuals with a confirmed or suspected stroke will be assessed by member of the stroke team
- Appropriate patients should be transferred to the Unit within 24 hours of admission to hospital [Box 2]
- Stroke Patients not admitted to the Unit should be transferred to the most appropriate Ward

**Box 2: Admission Criteria for Stroke Unit**
- Admission to the Unit may in part depend on the availability of beds. The priorities for admission are:
  - Definite diagnosis of Ischaemic or Haemorrhagic stroke
  - Provisional diagnosis of stroke?
- For each of these criteria patients should be stable, and at least rousable
- Patients not admitted but who would benefit from Stroke Unit care will be placed on a waiting list and transferred when a bed is available.
- If a patient’s condition changes while on another Ward (eg onset of stroke) they should be assessed by a member of the stroke team, and admitted if appropriate

**Box 3: Patients who should not be admitted to Stroke Unit**
- Patients who meet diagnostic criteria BUT
  - Medically unstable
Or are unable to participate in the rehabilitation process due to
  - Significant dementia
  - Severe behaviour problems
  - Learning Difficulties
  - Progressive Neurological deterioration

**Box 4: Discharge Planning & Criteria**
- Meeting patients needs and wishes, together with the availability of appropriate Services (Hospital or Community), and provision for follow-up, will inform timing and location of discharge from Unit
- Typically, discharge will be when:
  - Agreed goals have been met
  - Cease to benefit from active rehab
  - Input is refused/lack of compliance
  - Fit exclusion criteria AND/OR
    - Patient transferred to a new setting with appropriate care and rehabilitation to meet remaining goals
- Patient & carer needs for post-discharge Services are assessed
- Where rehabilitation/support needs are ongoing, appropriate and timely referrals should be in place and transfer planned and agreed
- Appropriate information should be provided for the patient, carers and family

**Box 5: Follow Up Services**
- Arrangements should be made for patients admitted with a stroke to be reviewed by the specialist/stroke service within three months of discharge.
- CHSS Stroke Nurse will visit / telephone the patient 2 week post discharge and follow up for the first year.
- *Ideally,* a further assessment should be performed by a member of the Primary Health Care Team 3 to 6 months after discharged to monitor: Level of impairment, post-stroke/discharge; Potential for further rehabilitation; Patient and Carer adjustment and Concordance with secondary prevention measures.